FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040865

Facility Name: Dixon Health Care Center

Address: 111 North Court (Number) Dixon (City) 61021 (Zip Code)

County: Lee

Telephone Number: (815) 288-1477 **Fax #** (815) 288-9512

IDPA ID Number: 75-2080781

Date of Initial License for Current Owners: 09/01/86

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		x	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Sherry DeBons **Telephone Number:** (281) 579-5022

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Linda Holtzscheiter

(Title) Reimbursement Manager

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) N/A

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Dixon Health Care Center # 0040865 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	26	Skilled (SNF)	26	3,940	1
2		Skilled Pediatric (SNF/PED)			2
3	84	Intermediate (ICF)	84	30,660	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	34,600	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,923	462	1,143	5,528	8
9	SNF/PED					9
10	ICF	12,140	6,166	108	18,414	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,063	6,628	1,251	23,942	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.20%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 09/01/86

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 09/01/86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 18 and days of care provided 1,143

Medicare Intermediary AdminStar Kentucky

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Dixon Health Care Center # 0040865 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	121,213	8,203	6,631	136,047		136,047		136,047			1
2	Food Purchase		123,582		123,582		123,582	(2,801)	120,781			2
3	Housekeeping	64,454	7,499		71,953		71,953		71,953			3
4	Laundry	42,060	7,609		49,669		49,669		49,669			4
5	Heat and Other Utilities			63,594	63,594		63,594	14	63,608			5
6	Maintenance	44,337	27,515	20,768	92,620		92,620	36	92,656			6
7	Other (specify):* Waste/ garbage -See Pg 3.1			13,491	13,491		13,491		13,491			7
8	TOTAL General Services	272,064	174,408	104,484	550,956		550,956	(2,751)	548,205			8
	B. Health Care and Programs											
9	Medical Director			5,500	5,500		5,500		5,500			9
10	Nursing and Medical Records	990,588	36,584	7,167	1,034,339		1,034,339	10,039	1,044,378			10
10a	Therapy	12,389	349	3,977	16,715		16,715		16,715			10a
11	Activities	54,738	2,121	2,946	59,805		59,805		59,805			11
12	Social Services	26,599		3,320	29,919		29,919		29,919			12
13	Nurse Aide Training											13
14	Program Transportation	20,628		12,020	32,648		32,648		32,648			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,104,942	39,054	34,930	1,178,926		1,178,926	10,039	1,188,965			16
	C. General Administration											
17	Administrative	75,678			75,678		75,678		75,678			17
18	Directors Fees											18
19	Professional Services			15,571	15,571		15,571	3,594	19,165			19
20	Dues, Fees, Subscriptions & Promotions			24,024	24,024		24,024	(9,699)	14,325			20
21	Clerical & General Office Expenses	59,669	3,755	143,992	207,416		207,416	(51,721)	155,695			21
22	Employee Benefits & Payroll Taxes			356,513	356,513		356,513		356,513			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,891	6,891		6,891	4,899	11,790			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			80,173	80,173		80,173	58,621	138,794			26
27	Other (specify):*											27
28	TOTAL General Administration	135,347	3,755	627,164	766,266		766,266	5,694	771,960			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,512,353	217,217	766,578	2,496,148		2,496,148	12,982	2,509,130			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Dixon Health Care Center #0040865 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			12,738	12,738		12,738	76,243	88,981			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(164)	(164)		(164)	164				32
33	Real Estate Taxes			60,581	60,581		60,581	166	60,747			33
34	Rent-Facility & Grounds							1,140	1,140			34
35	Rent-Equipment & Vehicles			9,129	9,129		9,129	2,597	11,726			35
36	Other (specify):* See Pg 4.1			(5,028,016)	(5,028,016)		(5,028,016)	5,033,778	5,762			36
37	**TOTAL Ownership**			(4,945,732)	(4,945,732)		(4,945,732)	5,114,088	168,356			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		27,341	500	27,841		27,841		27,841			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,225	60,225		60,225		60,225			42
43	Other (specify):* See Pg 4.1											43
44	**TOTAL Special Cost Centers**		27,341	60,725	88,066		88,066		88,066			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,512,353	244,558	(4,118,429)	(2,361,518)		(2,361,518)	5,127,070	2,765,552			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Dixon Health Care Center # 0040865 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,801)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	164	32		10
11	Discounts, Allowances, Rebates & Refunds		21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,230)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(475)	20		28
29	Other-Attach Schedule	5,035,926			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 5,031,584		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	95,486		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 95,486		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 5,127,070		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Dixon Health Care Center

ID# 0040865

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sales Taxes	$ (731)	21	1
2	Small Balance Adjustments	0	21	2
3	Memorium/ Benevolance	(268)	21	3
4	Depreciation Reconciliation	44,439	30	4
5	Activities Program Receipts	0	11	5
6	Depreciation Reconciliation	31,804	30	6
7	Professional Liability Insurance	58,306	26	7
8	Barber & Beauty	0	40	8
9	Public Relation Expense	(177)	20	9
10	Non Allowable Advertising	(9,474)	20	10
11	Entertainment	0	24	11
12	Fresh Start	5,028,016	36	12
13	Laundry Receipts	0	21	13
14	Vending Reciepts	(517)	21	14
15	Misc Reciepts	0	21	15
16	Marketing Wages	(16,972)	21	16
17	Maketing Bonus	0	21	17
18	Marketing Holiday	(383)	21	18
19	Marketing Sick	0	21	19
20	Marketing Vacation	(1,034)	21	20
21	Marketing Overtime	(26)	21	21
22	Legal Fees -Bankrupcty	0	21	22
23	Contributions -Donations	1,941	21	23
24	Mgt Fees Expense	(83,885)	21	24
25	Other direct Expense - Marketing	(734)	21	25
26	Gain/Loss on Sale of Assest -Adminstrative	1,064,352	21	26
27	Gain/Loss on Sale of Assest -Bankruptcy	(1,078,732)	21	27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	5,035,926		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Dixon Health Care Center # 0040865 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses A. General Services	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,801)	0	0	0	0	0	0	0	0	0	0	(2,801)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	14	0	0	0	0	0	0	0	0	0	14	5
6	Maintenance	0	36	0	0	0	0	0	0	0	0	0	36	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,801)	50	0	0	0	0	0	0	0	0	0	(2,751)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	10,039	0	0	0	0	0	0	0	0	0	10,039	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	10,039	0	0	0	0	0	0	0	0	0	10,039	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,594	0	0	0	0	0	0	0	0	0	3,594	19
20	Fees, Subscriptions & Promotions	(10,126)	427	0	0	0	0	0	0	0	0	0	(9,699)	20
21	Clerical & General Office Expenses	(118,218)	66,497	0	0	0	0	0	0	0	0	0	(51,721)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	4,899	0	0	0	0	0	0	0	0	0	4,899	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	58,306	315	0	0	0	0	0	0	0	0	0	58,621	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(70,038)	75,732	0	0	0	0	0	0	0	0	0	5,694	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(72,839)	85,821	0	0	0	0	0	0	0	0	0	12,982	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Dixon Health Care Center # 0040865 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	76,243	0	0	0	0	0	0	0	0	0	0	76,243	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	164	0	0	0	0	0	0	0	0	0	0	164	32
33	Real Estate Taxes	0	166	0	0	0	0	0	0	0	0	0	166	33
34	Rent-Facility & Grounds	0	1,140	0	0	0	0	0	0	0	0	0	1,140	34
35	Rent-Equipment & Vehicles	0	2,597	0	0	0	0	0	0	0	0	0	2,597	35
36	Other (specify):*	5,028,016	5,762	0	0	0	0	0	0	0	0	0	5,033,778	36
37	**TOTAL Ownership**	5,104,423	9,665	0	0	0	0	0	0	0	0	0	5,114,088	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,031,584	95,486	0	0	0	0	0	0	0	0	0	5,127,070	45

Facility Name & ID Number Dixon Health Care Center # 0040865 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mariner Health Care	100	See Attached page 6.1		Mariner Health Care	Atlanta, GA	Management

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Mariner Health Care	100.00%	$ 14	$ 14	1
2	V	6	Repair & Maintenance		Mariner Health Care	100.00%	36	36	2
3	V	19	Professional Services		Mariner Health Care	100.00%	3,594	3,594	3
4	V	20	Fees, Subscription, Promotions		Mariner Health Care	100.00%	427	427	4
5	V	10	Nursing & Medical Records		Mariner Health Care	100.00%	10,039	10,039	5
6	V	21	Clerial & General Office Exp		Mariner Health Care	100.00%	66,497	66,497	6
7	V	24	Travel & Seminar		Mariner Health Care	100.00%	4,899	4,899	7
8	V	26	Insurance Premium		Mariner Health Care	100.00%	200	200	8
9	V	36	Depreciation		Mariner Health Care	100.00%	5,762	5,762	9
10	V	33	Taxes - Property		Mariner Health Care	100.00%	166	166	10
11	V	35	Rental & Leasing		Mariner Health Care	100.00%	2,597	2,597	11
12	V	34	Lease Expense		Mariner Health Care	100.00%	1,140	1,140	12
13	V	26	Property Insurance		Mariner Health Care	100.00%	115	115	13
14	Total			$			$ 95,486	$ * 95,486	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Dixon Health Care Center # 0040865 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Dixon Health Care Center # 0040865 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Mariner Health Care
Street Address: One Ravine Dr. Suite 1500
City / State / Zip Code: Atlanta, GA 30346
Phone Number: ((770) 379-8203
Fax Number: ((770) 399-1971

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities				$ 192	$		$ 14	1
2	6	Repair & Maintenance				556			36	2
3	19	Professional Services				50,336			3,594	3
4	20	Fees, Subscription, Promotions				6,593			427	4
5	10	Nursing & Medical Records				675,703			10,039	5
6	21	Clerial & General Office Exp				527,522			66,497	6
7	24	Travel & Seminar				84,515			4,899	7
8	26	Insurance Premium				2,427			200	8
9	36	Depreciation				81,021			5,762	9
10	33	Taxes - Property				2,346			166	10
11	35	Rental & Leasing				35,937			2,597	11
12	34	Lease Expense				15,801			1,140	12
13	26	Property Insurance				1,581			115	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,484,530	$		$ 95,486	25

Facility Name & ID Number Dixon Health Care Center # 0040865 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Dixon Health Care Center # 0040865 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 40,337	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 70,902	2
3. Under or (over) accrual (line 2 minus line 1).		$ 30,565	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 30,182	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 60,747	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	42,404	8
	1998	46,169	9
	1999	47,121	10
	2000	44,583	11
	2001	40,902	12

Line 1 adjusted or not equal to prior C/R due to intercompany entries.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Dixon Health Care Center COUNTY Lee

FACILITY IDPH LICENSE NUMBER 0040865

CONTACT PERSON REGARDING THIS REPORT Sherry DeBons

TELEPHONE 281-579-5022 FAX #: 281-578-4779

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-02-32-126-005	00000141 north Ct, assrs plt2 nh, pt It	$ 40,901.74	$ 40,901.74
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 40,901.74	$ 40,901.74

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Dixon Health Care Center # 0040865 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,710 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1993	$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Dixon Health Care Center # 0040865 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	110		1993	1976	$ 1,100,000	$ 31,429	35	$ 31,429	$	$ 289,561	4
5			1993		185,306	9,266	20	9,266		123,750	5
6											6
7											7
8											8
	Improvement Type**										
9	Parking Lot Repairs			1996	2,925	146	20	146		920	9
10	Architect - Transicare Unit			1996	548	27	20	27		183	10
11	Door & Frame			1996	2,215	111	20	111		701	11
12	Tile flooring			1996	7,000	350	20	350		2,172	12
13	Painting			1996	3,115	156	20	156		959	13
14	Door & Frame			1996	2,215	111	20	111		679	14
15	Install Ceiling			1996	6,905	345	20	345		2,110	15
16	Laundry Repair			1996	3,314	166	20	166		1,072	16
17	Floor Ceramic Tile			1997	5,334	267	20	267		1,601	17
18	Paint Building			1997	3,021	151	20	151		841	18
19	Carpet			1997	1,439	72	20	72		402	19
20	Gutters & Windows			1997	2,932	147	20	147		783	20
21	Walls & Floors			1997	1,100	55	20	55		281	21
22	Storefront Construction			1998	8,353	209	20	209		1,045	22
23	Concrete Foundation			1998	720	36	20	36		180	23
24	Roof covering/Gutters			1998	16,491	412	20	412		2,060	24
25	Dumpster area			1998	500	25	20	25		125	25
26	HVAC			1998	8,395	420	20	420		2,100	26
27	Security Systems			1998	2,284	114	20	114		570	27
28	Curtain & Drapes			1998	1,985	99	20	99		495	28
29	AT & T Phones Systems			1993	6,676	668	20	334	(334)	4,358	29
30	HVAC Units			1994	1,787	179	20	89	(90)	1,079	30
31	HVAC Units			1994	2,680	268	20	134	(134)	1,621	31
32	HVAC Compressor			1994	2,747	275	20	137	(138)	1,562	32
33	A/C (5)			1995	4,964	496	20	248	(248)	2,464	33
34	A/C Units			1996	4,144	414	20	208	(206)	1,716	34
35	A/C (12)			1996	11,644	1,164	20	582	(582)	4,677	35
36	A/C Units			1996	1,057	106	20	53	(53)	409	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Dixon Health Care Center # 0040865 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	A/C Fan Motors	1996	$ 583	$ 58	20	$ 29	$ (29)	$ 220	37
38	A/C Heating	1996	1,145	115	20	57	(58)	322	38
39	Base Heaters	1996	1,908	191	20	95	(96)	702	39
40	Curtain & drapes	1996	2,800	280	20	140	(140)	1,000	40
41	Water Storage Tank	1996	1,114	111	20	56	(55)	381	41
42	Curtains & Drapes	1997	10,592	1,059	20	530	(529)	3,586	42
43	Drapes Installation	1997	820	82	20	41	(41)	255	43
44	Elevator Repairs	1997	6,780	678	20	339	(339)	2,172	44
45	Hot water Booster	1997	851	85	20	43	(42)	266	45
46	Cubicle Curtain	1997	6,857	686	20	343	(343)	2,061	46
47	A/C Units (6)	1997	6,251	625	20	313	(312)	1,831	47
48	Security System	1997	2,284	228	20	114	(114)	592	48
49	Cubicle Curtain	1997	4,952	495	20	248	(247)	1,320	49
50	Reconciling Adjustment to WTB 1998	1998		14,956			(14,956)		50
51	Landscraping	1998	1,198	30	20	30		150	51
52									52
53	4: RA/C Quiet Zone 660	1999	1,280	256	5	256		896	53
54	electrical work	1999	180	9	20	9		31	54
55	Plumbing Water Heater	1999	666	67	10	67		228	55
56	1: Lochinvar Copper	1999	4,366	437	10	437		1,492	56
57	Partial Elevator Door	1999	8,024	401	20	401		1,471	57
58	Nurse Call Sytem	2000	1,986	199	10	199		612	58
59	Install Charge, nurse Call Sysrem	2000	1,415	142	10	142		401	59
60	Nurse Call, Second Install Fee	2000	2,000	200	10	200		517	60
61	2: Retroaire Chassis, Dining Rm	2000	2,458	492	5	492		1,270	61
62	Install 4" Steel Fire Line	2000	1,132	45	25	45		117	62
63	Fire Alarm Panel instld	2000	919	92	10	92		230	63
64	Rplc 4" Gas Main Labor Only	2000	662	26	25	26		68	64
65	Rplc 4" Gas Main	2000	802	32	25	32		83	65
66	Core Grade Swail, Water Drain	2000	3,405	227	15	227		568	66
67	Bldg Grounds Reeinforced, Drains	2000	3,900	260	15	260		650	67
68	Rprs 7,304 Sqft Roof Patches	2001	39,400	3,940	10	3,940		4,925	68
69	7403 Sqft Roof Reapirs	2001	39,400	3,940	10	3,940		4,597	69
70	TOTAL (lines 4 thru 69)		$ 1,561,926	$ 78,127		$ 59,041	$ (19,086)	$ 483,489	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Dixon Health Care Center # 0040865 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,561,926	$ 78,127		$ 59,041	$ (19,086)	$ 483,489	1
2	30: Boiler System Values -48%	2002	5,072	85	20	85		85	2
3	Use Tax - 30: Boiler System Values -48%	2002	317	5	20	5		5	3
4	Values, Drain/refill system Instl	2002	4,060	339	20	339		339	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,571,374	$ 78,556		$ 59,470	$ (19,086)	$ 483,917	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Dixon Health Care Center # 0040865 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 295,147	$ 29,476	$ 29,476	$	var	$ 220,100	71
72	Current Year Purchases	1,061	35	35		var	35	72
73	Fully Depreciated Assets	45,400					45,400	73
74								74
75	TOTALS	$ 341,608	$ 29,511	$ 29,511	$		$ 265,535	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,912,982	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 108,067	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 88,981	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (19,086)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 749,452	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	O/H Allocation 1996	$ 4,649	$ 232	$ 1,423	86
87	O/H Allocation 1997	2,976	149	804	87
88					88
89					89
90					90
91	TOTALS	$ 7,625	$ 381	$ 2,227	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Dixon Health Care Center # 0040865 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 3,395 Description: Dishwasher, Copier, Water Cooler - see Attached Pg 14.1
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Medical Transporation	1999 Ford F350 Van	$ 915.00	$ 9,129	17
18	Activites				18
19					19
20					20
21	TOTAL		$ 915.00	$ 9,129	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Dixon Health Care Center # 0040865 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	49 hrs	$ 1,455		$	$ 0	49	$ 1,455	1
2	Licensed Speech and Language Development Therapist	10a	hrs		36	396	0	36	396	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs		320	1,680	95	320	1,775	4
5	Physician Care		visits							5
6	Dental Care	39	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				15,034		15,034	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39				500			500	13
14	TOTAL			$ 1,455	356	$ 2,576	$ 15,129	405	$ 19,160	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Dixon Health Care Center # 0040865 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 580	$	1
2	Cash-Patient Deposits	86,717		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	(180,748)		3
4	Supply Inventory (priced at)	20,565		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	126,045		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 53,159	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	101,386		13
14	Buildings, at Historical Cost	231,686		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	93,079		16
17	Accumulated Depreciation (book methods)	(211,268)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See attachment Schd 17.1			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 214,883	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 268,042	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 11,509	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	115,804		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,182		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schd 17.1			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 157,495	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See attached Schd 17.1			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 157,495	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 110,547	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 268,042	$	48

*(See instructions.)

Facility Name & ID Number Dixon Health Care Center # 0040865 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (5,275,291)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (5,275,291)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	4,613,274	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 4,613,274	17
	B. Transfers (Itemize):		
18	**Fresh Start Acctg Due to Bankrupty**	772,563	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 772,563	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 110,546	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Dixon Health Care Center # 0040865 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,758,787	1
2	Discounts and Allowances for all Levels	(637,666)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,121,121	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	49,128	6
7	Oxygen	5,198	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 54,326	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,662	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	46,398	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	323	19
20	Radiology and X-Ray		20
21	Other Medical Services	15,934	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 67,317	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Receipts	517	28
28a	Miscellanceous Receipts	8,475	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,992	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,251,756	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	550,956	31
32	Health Care	1,178,926	32
33	General Administration	766,266	33
	B. Capital Expense		
34	Ownership	(4,945,732)	34
	C. Ancillary Expense		
35	Special Cost Centers	27,841	35
36	Provider Participation Fee	60,225	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ (2,361,518)	40
41	**Income before Income Taxes (line 30 minus line 40)****	4,613,274	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 4,613,274	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Dixon Health Care Center # 0040865 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,752	1,904	$ 45,271	$ 23.78	1
2	Assistant Director of Nursing	254	276	5,159	18.69	2
3	Registered Nurses	12,466	13,546	267,371	19.74	3
4	Licensed Practical Nurses	9,201	9,997	161,814	16.19	4
5	Nurse Aides & Orderlies	46,175	50,174	504,671	10.06	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	49	50	1,502	30.04	7
8	Rehab/Therapy Aides	422	434	10,886	25.08	8
9	Activity Director	1,667	1,833	21,481	11.72	9
10	Activity Assistants	4,390	4,828	33,257	6.89	10
11	Social Service Workers	2,034	2,146	26,599	12.39	11
12	Dietician					12
13	Food Service Supervisor	1,787	1,952	25,273	12.95	13
14	Head Cook	5,883	6,426	55,048	8.57	14
15	Cook Helpers/Assistants	5,794	6,329	40,891	6.46	15
16	Dishwashers					16
17	Maintenance Workers	3,745	4,107	44,337	10.80	17
18	Housekeepers	7,817	8,485	64,454	7.60	18
19	Laundry	5,617	5,922	42,060	7.10	19
20	Administrator	1,989	2,247	72,238	32.15	20
21	Assistant Administrator	639	722	11,580	16.04	21
22	Other Administrative	1,821	2,057	25,612	12.45	22
23	Office Manager					23
24	Clerical	777	877	7,503	8.56	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	547	563	6,202	11.02	31
32	Other Health Ca MCare Coord/ Case Mgt					32
33	Other(specify) Mkting & Transpo	3,017	3,366	39,763	11.81	33
34	TOTAL (lines 1 - 33)	117,843	128,241	$ 1,512,972 *	$ 11.80	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	147	$ 5,898	1 - 3	35
36	Medical Director	96	55,000	9 - 3	36
37	Medical Records Consultant	0	0	10-3	37
38	Nurse Consultant	220	10,039	10- 7	38
39	Pharmacist Consultant	115	4,950	10 - 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	54	2,946	11 - 3	44
45	Social Service Consultant	60	5,898	12 - 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	692	$ 84,731		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	20	$ 908	10 - 3	50
51	Licensed Practical Nurses	8	266	10 - 3	51
52	Nurse Aides	45	903	10 - 3	52
53	TOTAL (lines 50 - 52)	73	$ 2,076		53

Facility Name & ID Number Dixon Health Care Center # 0040865 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lori F. Cain	Adminsrtator	100	$ 65,756
Traci Wagner	Adminsrtator	100	9,922
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 75,678

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
		$
Legal (SEE ATTACHED)	Legal Fees	15,571
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 15,571

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,060
Unemployment Compensation Insurance	61,432
FICA Taxes	111,946
Employee Health Insurance	129,212
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension/Retirement	3,341
Insurance Life	2,216
Other Benefits	1,306
Home Office Allocation	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 356,513

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,940
Health Care Worker Background Check	
(Indicate # of checks performed)	3,168
Other Licenses Fees	1,283
Dues	6,301
Home Office Allocation	427
Total Advertising	10,332
Rounding	6
Less: Public Relations Expense	(177)
Non-allowable advertising	(9,479)
Yellow page advertising	(475)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,325

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,360
Home Office Allocation	4,899
Seminar Expense	3,531
Entertainment Expense	(0)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,790

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Dixon Health Care Center # 0040865 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Dixon Health Care Center # 0040865 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois HealthCare Association - $ 5,262**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,356** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **60,225**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

STATE OF ILLINOIS

Facility Name & ID Number Dixon Health Care Center # 0040865 **Ending:** 12/31/2002

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Operating Expense - Line 7	Amount
Infectious Waste Disposal <> Default <> Nursing Admin/Supv	8,807
Infectious Waste Disposal <> Default <> Physical Plant	30
Garbage Service <> Default <> Physical Plant	4,655
	13,491

Health Care Program - Line 15	Amount
N/A	
	0

General & Adminstrative - Line 27	Amount
N/A	
	0

Inservice Education - Line 23 Column 3 (over $2,000)	Amount
N/A	
	0

STATE OF ILLINOIS

Facility Name & ID Number Dixon Health Care Center # 0040865 Ending: 12/31/2002

Meals - adjustment

23,942	Days (Total Patient days)
3	Mult (3 meals a day)
71826	Sub total
1666	meals to employess (reported by facility)
73492	Add Sub
123,582	Divide -Pg 3, line 2, column 2
1.68	Cost per meal

1.68	Cost per meal
1666	mult - meal to employees
2,801	= adjust for pg 2, line 2, column2

STATE OF ILLINOIS

Facility Name & ID Number Dixon Health Care Center # 0040865 Ending: 12/31/2002

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Ownership - Line 36	Amount
Fresh Start Acctg Adj <> Bankrupty Exp Acq <> Cost Non Overhead	(5,028,016)
Home Office - Depreciation	5,762
	(5,022,254)

Ancillary Expenses - Line 43 -Column 2	Amount
Ancillary Supplies <> Default <> Laboratory	0
	0

Ancillary Expenses - Line 43 -Column 3	Amount
Contract Svcs - Chgbl <> Default <> Laboratory	0
Contract Svcs - Chgbl <> Default <> X/Ray	0
Professional Services Chgble <> Default <> X/Ray	0
Professional Services Chgble <> General / Other <> X/Ray	0
	-

Related Illinois Nursing Homes as of 12/31/2002

Group Name	Related Illinois Nursing Homes	Illinois Facility Number
Mariner Health Care	Dixon HealthCare Center	0040865
	LaSalle Health & Rehabilitation Center	0037671
	Litchfield HeathCare Center	0037689
	Montebello HeathCare Center	0031468
	Nature Trail HealthCare Center	0039586
	Odin HeathCare Center	0039503
	Parkway HealthCare Center	0040857
	Mariner Health of Westchester	0042374

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIES

Line 9

OTHER CURRENT ASSETS:	AMOUNT
Total	0
Reconcile with schedule XV, line 9:	0

Difference 0

Line 36

OTHER CURRENT LIABILITIES:	AMOUNT
Misc Dedctns - Employee <> Other Decductions <> Default	-
Misc Dedctns - Employee <> Union Dues <> Default	-
Accruals - Insurance <> Accrue HMO Ins <> Default	-
Accruals - Insurance <> Self Funded Ins Accr <> Default	-
Accruals - Insurance <> Basic Life <> Default	-
Accruals - Insurance <> Lt Dsblty <> Default	-
Accruals - Insurance <> Executive Supp Life <> Default	-
Accruals - Insurance <> Short Term Disability <> Default	-
Accruals - Insurance <> Dependent Life <> Default-Dept	-
Accruals - Insurance <> Accidental Death Dismemberment <> Defa	-
Accruals - Insurance <> NES Insurance <> Default-Dept	-
Misc Dedctns - Employee <> Miscellaneous <> Default	-
Deferred Income <> Deferred Revenue-Blood Glucose <> Default	-
L/T Debt - Current Portion <> Current Portion <> Default	-
Total	-
Reconcile with schedule XV, line 36:	0

Difference -

Line 23

OTHER NON-CURRENT ASSETS:	
Asset Clearing <> Default-Prod <> Default-Dept	-
Asset Clearing <> Default <> Realty	-
Asset Clearing <> Capital Expenditures <> Realty	-
Asset Clearing <> Fresh Start Valuation <> Realty	-
Asset Clearing <> PS AM Capital Expenditures <>FS Realty	-
Asset Clearing <> FAS 121 Impairment Valuation <> Realty	-
Other Assets <> Rfndable Deposits-Int Bearing <> Default	
Excess Reorganized Value <>Excess Reorg Value <> Default	-
Other Assets <> Rfndable Deposits-Non Int Brg <> Default	-
Total	-
Reconcile with schedule XV, line 23:	0

Rounding to bal page

Difference -

Line 43

OTHER NON-CURRENT LIABILITIES::	
N/P - Mortgage <> Mortgages <> Default	-
Mortgage Cost <> Current Position <> Default	-
Long Term Debt - Other <> Other <> Default	-
Intercompany - Revolver <> Default <> Default	-
I/C Term Loan 1998 <> Default-Prod <> Default-Dept	-
I/C Term Loan 1999 <> Default-Prod <> Default-Dept	-
I/C - Interunit Asset Transfer <> Default-Prod <> Default-Dept	-
Compromised Liabilities <> Default	-
Other Non-Current Lby <> Rent Accrual <> Default	-
Other Non-Current Lby <> Other <> Default-Dept	-
Other Non-Current Lby <> Overmarket Lease <> Default-Dept	-
Total	-
Reconcile with schedule XV, line 43:	0

Difference 0

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIES

DESCRIPTION	AMOUNT
Personal Purchase Receipts <> Default <> Vending	(517)

	Total	-517	Difference
Reconcile with schedule XVII, line 28:		(517)	(0)

DESCRIPTIONS

General Revenue <> (General) <> Other	0.00
General Revenue <> (General) <> Other Misc Rev	0.00
Personal Purchase Receipts <> Default <> Patient Personal Purchase	-
Personal Purchase Receipts <> Default <> Miscellaneous Receipts	(8,811)
Personal Purchase Expense <> Default <> Patient Personal Purchase	335
Miscellaneous Receipts <> Default-Prod <> Other Misc Rev	-
Activity Programs Receipts <> Default <> Other Misc Rev	-

			Rounding
	Total	(8,475)	Difference
Reconcile with schedule XVII, line 28a:		(8,475)	0